

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
**DYSKINESIA IDENTIFICATION SYSTEM:
DISCUS RATING**

SCORING ABNORMAL INVOLUNTARY MOVEMENTS:								
0	=	NOT PRESENT	(Movements not observed or not considered abnormal)					
1	=	MINIMAL	(Abnormal movements are difficult to detect, or occur only once or twice in a non-repetitive manner)					
2	=	MILD	(Abnormal movements occur infrequently but are easy to detect)					
3	=	MODERATE	(Abnormal movements occur frequently and are easy to detect)					
4	=	NOT PRESENT	(Abnormal movements occur almost continuously and are easy to detect)					
NA = NOT ASSESSED								
FACIAL								
01. Tics			0	1	2	3	4	NA
02. Grimaces			0	1	2	3	4	NA
OCULAR								
03. Blinking			0	1	2	3	4	NA
ORAL								
04. Chewing/lip smacking			0	1	2	3	4	NA
05. Puckering/sucking/thrusting lower lip			0	1	2	3	4	NA
LINGUAL								
06. Tongue thrusts			0	1	2	3	4	NA
Tongue in cheek			0	1	2	3	4	NA
07. Tonic tongue			0	1	2	3	4	NA
08. Tongue tremor			0	1	2	3	4	NA
09. Athetoid/Myokymic/Lateral tongue			0	1	2	3	4	NA
HEAD/NECK/TRUNK								
10. Retrocollis/Tortollis			0	1	2	3	4	NA
11. Shoulder Hip Torsion			0	1	2	3	4	NA
UPPER LIMB								
12. Athetoid/Myokymic/finger/wrist/arm			0	1	2	3	4	NA
13. Pill rolling			0	1	2	3	4	NA
LOWER LIMB								
14. Ankle Flexion/foot tapping			0	1	2	3	4	NA
15. Toe movement			0	1	2	3	4	NA
OTHER								
Self-stim behavior			0	1	2	3	4	NA
Cerebral palsy			0	1	2	3	4	NA
			0	1	2	3	4	NA
			0	1	2	3	4	NA
			0	1	2	3	4	NA
			0	1	2	3	4	NA

NAME	ID OR UNIT
DATE	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
TOTAL SCORE:	
COOPERATION LEVEL (CHECK ONE)	
<input type="checkbox"/> NO COOPERATION: Some resistance, few if any exam steps done. <input type="checkbox"/> PARTIAL COOPERATION: Some but not all exam steps done <input type="checkbox"/> FULL COOPERATION: Most or all exam steps done	
POSSIBLE RISK FACTORS (CHECK/COMPLETE ALL THAT APPLY)	
<input type="checkbox"/> 1. Age (specify): _____ <input type="checkbox"/> 2. Sex (specify): _____ <input type="checkbox"/> 3. Denures/no teeth <input type="checkbox"/> 4. Seizures <input type="checkbox"/> 5. Senility <input type="checkbox"/> 6. Neuro-degenerative disease <input type="checkbox"/> 7. Neuro-muscular disease <input type="checkbox"/> 8. Use of anti-Parkinson drugs <input type="checkbox"/> 9. Other (specify): _____	
GLOBAL JUDGMENT	
1. Severity of movements: <input type="checkbox"/> 0 None or Minimal <input type="checkbox"/> 2 Mild <input type="checkbox"/> 4 Severe <input type="checkbox"/> 1 Minimal <input type="checkbox"/> 3 Moderate	
2. Incapacitation due to abnormal movements: <input type="checkbox"/> 0 None or Minimal <input type="checkbox"/> 2 Mild <input type="checkbox"/> 4 Severe <input type="checkbox"/> 1 Minimal <input type="checkbox"/> 3 Moderate	
3. Client awareness of abnormal movements: <input type="checkbox"/> 0 None or Minimal <input type="checkbox"/> 2 Mild <input type="checkbox"/> 4 Severe <input type="checkbox"/> 1 Minimal <input type="checkbox"/> 3 Moderate	
RATER CONCLUSIONS (CHECK APPROPRIATE BOXES)	
<input type="checkbox"/> A. No abnormal involuntary movements observed <input type="checkbox"/> B. Abnormal involuntary movements observed <input type="checkbox"/> 1. Not diagnosed previously <input type="checkbox"/> 2. Not seen previously <input type="checkbox"/> 3. Increased frequency or intensity <input type="checkbox"/> 4. Decreased frequency or intensity <input type="checkbox"/> C. Abnormal involuntary movements observed, previously diagnosed as being due to: _____	
COMMENTS	
SCREENED, PHYSICIAN, PA, OR APR SIGNATURE	